EDITORIAL

In Defense of Health Care

IT MAY HAVE BEEN NOTED that the writer of many of the editorials appearing in these columns has used the terms medical care and health care more or less interchangeably. This has been disturbing to some who believe that physicians have responsibility for medical care but cannot be held responsible for health care. Spokesmen for one large medical association have gone so far as to define medical care as that portion under the control of the physician, and health care to include social, economic and environmental influences beyond the control of medicine. But this distinction is hard to maintain, particularly when there is considerable evidence that the role of the physician is substantially diminishing in much that is medical care and is substantially increasing in much that is called health care.

The distinction is further blurred by the increasing use of the word health in medicine and medical care and by the increasing number of meanings and connotations which are being given to this word. The terms health insurance, health benefits, health centers, health sciences, health maintenance and health screening all clearly pertain to medical care. And in another dimension health and even medical care are being linked to the concepts of well-being and even the quality of life, concepts which have not traditionally been considered part of medicine and do not necessarily depend upon the absence of disease or infirmity. But linked they are becoming, and one can even sense a return to the all embracing root meaning of the word health in which the words heal and whole come together as one.

In any case physicians really no longer have true control of medical care, if indeed they ever did. And it is equally true that physicians no longer can remain aloof or apart from the social, economic and environmental influences on health and well-being, if indeed they ever could. When one gets right down to it, health is what medicine is all about, whether one is talking about coping with illness or injury; adjusting to stresses in the internal or external environments; striving to achieve, restore or maintain physical and mental well-being (as health is defined by the American Medical Association), or physical, mental and social well-being (as it is defined by the World Health Organization).

For these and many other reasons the distinction between medical care and health care seems no longer to be very important, and if anything—to this writer at least—health care seems to be the more inclusive and therefore the more useful term.

—MSMW

The Diagnosis of Obstructive Jaundice

THE DIFFERENTIATION between surgically correctable and noncorrectable causes of cholestatic jaundice remains a diagnostic challenge.

In the past decade, the multiplicity of the conditions not amenable to surgical operation—largely drug-related hepatitis—has greatly increased, and now constitutes a large share of such conditions. In general, for that portion, there is usually no effective treatment as yet, other than removal of an offending drug or toxin and general support.

But the *early* recognition of the surgically remediable conditions remains highly important to permit their correction before the hepatic status has deteriorated, a localized tumor has spread or bacterial cholangitis has developed or extended.

Each physician must develop his own strategy of diagnostic approach to these conditions. His

choice of diagnostic methods and sequences will vary with his experience, the availability of specific procedures to him and, especially, the personal skills and record of accuracy and morbidity of persons offering these. As new procedures and opportunities appear, one's strategy must adapt.

In this issue of the JOURNAL a group of interdepartmental authorities at the University of Oregon Hospital present their current formula for approaching these conditions. They have been leaders in developing and demonstrating the application of the three major diagnostic procedures described. Applying these with great personal skill, their scheme of approach to sorting out cholestatic jaundice is logical and their results impressive. Groups of physicians elsewhere, with the availability of a different array of procedures and skills, would need to select somewhat different methods and sequences; however, the same general sorting schemes should hold.

Endoscopic retrograde cannulation of the biliary ducts (ERCB) is dramatically and rapidly replacing percutaneous transhepatic cholangiography for delineating the gross anatomy of the main biliary tree. It offers an immediate and decisive identification of gross bile duct obstructions, usually with much less morbidity than occurs with transhepatic cholangiography. ERCB requires great personal skill, and will never be within the standard armamentarium of the "routine" good fiberendoscopist. In skilled and experienced hands, it is successful in at least 85 percent of patient tries. In medical centers where ERCB is not yet adequately available, percutaneous transhepatic cholangiography may still be pursued with reasonable success. The technique for this procedure has undergone improved modifications recently, such as those described by a Japanese group.[1] Its accuracy and morbidity varies widely from center to center, and it is certainly highly unpopular and even dangerous in many.

The Department of Radiology at the University of Oregon is one of relatively few in this country highly capable in doing transjugular cholangiography (TJC). ERCB, as a less invasive procedure, is far more attractive. However, as a back up for solving ERCB procedure failures, TJC has attraction in those institutions possessing the skill, and is probably less risky than a percutaneous approach.

Many readers will be surprised to read the statement that selective visceral angiography "is of great value in the differential diagnosis of obstructive jaundice." This is probably entirely true in Josef Rösch's meticulous master's hands, but not so for the ordinary angiographer. In the latter setting, angiography should be viewed as a valuable accessory technique to search for anticipated hepatic metastases, to define limits of expanding tumors and to outline the position of major vessels preoperatively in order to plan more accurate surgical approaches. Dr. Rösch emphasizes the wisdom of doing angiography before transjugular cholangiography, in order to increase the safety of TJC.

After the easier patient material has been sorted and identified, needle liver biopsy by any route is usually very disappointing for differentiating the remainder. The tiny fragments obtained by the transjugular approach from areas adjacent to major vascular trunks would usually be considered inadequate and nonrepresentative of the main hepatic parenchyma—a very poor substitute for the 1.5 to 2 cm long cylinders usually obtained by the standard percutaneous method.

The authors have wisely relegated nuclear scanning to a minor place in this particular problem. Its definition of hepatic metastases is not often found in livers that are of relatively normal size, and rose bengal scans, in general, have a rather poor record for differentiating extrahepatic biliary obstruction from intrahepatic cholestasis.

"Minilap," developed by Dr. David State and his associates,[2] and similarly reported by Wexler et al,[3] is undoubtedly a very reasonable—though more invasive—immediate and definitive approach in selected cases, to be employed by skilled interdepartmental teams. Similarly, peritoneoscopic combined needle liver biopsy, transhepatic cholangiography and selective transhepatic portal venography is found useful in certain centers in western Europe.

In many hospitals in this country, early exploratory full laparotomy is still practiced for this diagnostic problem. Though the outcome may be satisfactory for roughly half such cases, the failure to obtain additional preoperative information through the types of procedures herein described often increases operative morbidity, necessitates a further full laparotomy and in some instances is simply disastrous.

Even in the future, some of the more definitive diagnostic procedures for these conditions which require great skill will be available only in large medical centers. A primary care physician should

be alert to refer selected patients sufficiently early in the course of their puzzling cholestatic jaundice to those locations where appropriate measures can be applied for the best advantage of the patient.

As the number of available procedures in the larger medical centers increases, physicians in these centers are also required to make wise decisions about how much of the potential comprehensive information is truly needed—in relation to expense and morbidity—in order to solve expeditiously each jaundiced patient's diagnosis and define treatment. In this connection, I applaud the diagnostic approach of the Oregonians, who choose early the least invasive, usually decisive procedures, which are relatively few in total number.

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Probabilities and Patient Care

EVERY PRACTICING PHYSICIAN lives with the reality of probabilities in patient care. Almost every one of his acts or decisions is the result of his assessing the probabilities of benefit to the patient as against the probabilities of complications or an untoward outcome. In each instance he is aware of the statistical possibilities of unwanted complications or undesired outcome and in each instance he takes this into account. Sometimes the probabilities involved are known rather precisely and sometimes they are not. Often the urgency is such that decisions must be made and action taken using incomplete information. Always there is a risk involved, for both physician and patient, when any decision is made or any action taken in patient care. Sometimes the risk is large as when an experimental treatment is undertaken for an as yet incurable disease, and sometimes it is almost infinitesimal as when prescribing an aspirin tablet for a patient not known to be sensitive to aspirin. But the risk and the possibility of an undesired result based on the probabilities inherent in the situation are always present.

When such an undesired result occurs, the patient or the patient's family, or an attorney who may be involved, may see this as an injustice to the patient or due to some mistake by the physician, and therefore seek compensation or damages through the courts. The question of any malicious intent on the part of the physician is almost never at issue. Rather the presumption is that since things did not turn out right something must have gone wrong somewhere and therefore someone or something should be held to account. In instances where actual malpractice has occurred this is valid enough. But when the practice was correct yet the result was an unwanted one, it is quite likely that the particular case fell within the lesser but nevertheless very real statistical probability of an undesirable outcome.

Natural science recognizes probabilities such as these and so does mathematics, which is the language of the natural sciences. Unfortunately the laws which men make to govern themselves are generally based on a different premise and tend not to reflect these probabilities which are so fundamental to natural and biological law—and to patient care. In consequence, the public view seems to be that when a patient is so unfortunate as to find himself among that portion or percentage whom the natural probabilities predict will have an unfortunate or less than perfect result, that patient is thought somehow to have been wronged. This view is now so widely held and has reached such proportions that the mechanisms of providing compensation to patients for this kind of misfortune are proving unequal to the task and a major crisis in patient care is rapidly developing.

An article appearing in this issue addresses the very basic problem of finding some way to bring a scientific assessment of probabilities in patient care to bear in the law as it affects medical practice. It could be an important pioneering contribution to the vexing and so far unsolved "malpractice" problem which now plagues both medicine and the society it is trying to serve.

—MSMW